SBHIS INSURANCE SERVICES

APP:
EFFE:
HRA:
SEP:

SOURCE: _____

DATE: _____

TIME: _____

Name: _____

DOB: ____/____/_____ **ID#** _____

Medicare #: _____

Part A: ____/ 01 /____ **Part B:** ____/ 01 /____ **LIS:** ___

Medi-cal #: _____

Plan Name: _____ **Policy:** _____

IPA: _____

PCP: Dr. _____

Doctor's Phone: (_____)_____-_____

Specialist:

1. **Dr.** _____
2. **Dr.** _____
3. **Dr.** _____
4. **Dr.** _____
5. **Dr.** _____

Address:

_____

_____

SOCIAL: _____

Phone #'s:

(_____)_____-_____

(_____)_____-_____

Email:

_____

Appointment:

Date: _____/_____/_____

Time: _____:_____ AM PM

Appt Type: In-Home In-Office Phone

Chronic conditions:

- ☐Diabetic/Diabetes
- ☐High Blood Pressure
- ☐Cardiovascular/Heart Condition

Prescriptions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Hospital: _____

VA: YES NO

Pharmacy: _____

Needed Benefits:

- ☐Dental
- ☐Vision
- ☐Transportation
- ☐Hearing
- ☐Personal Emergency
- ☐Chiropractic
- ☐Acupuncture
- ☐OTC
- ☐Flex Card
- ☐Groceries
- ☐Part B Rebate
- ☐Gym/Fitness